PPIP

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Statement of Confidentiality

This essay is a reflective account of an incident from practice placement involving one service user. I will obey the Department of Health's Confidentiality: NHS Code of Practice (2003) by anonymising the service user throughout the essay and a pseudonym of 'Mike' will be implemented.

This essay will be a reflective account of a critical incident I was involved in during my most recent clinical placement as a student mental health nurse. Reflecting on this incident will allow me to learn from my experience to improve my practice (Bassot, 2015, p. 2). Also reflection is a crucial aspect of professional development and life-long learning from practice (Scullion and Guest, 2007, p. 83).

Scullion and Guest (2007, p. 92) define a critical incident as an incident which is significant to student learning and it is felt that we actually learn from problematic experiences the greatest (Osterman and Kottkamp, 2004, cited in: Bassot, 2015, p. 59).

I will structure my reflection using the Driscoll (2007) model known as "The What? Model of structured reflection", a development of his initial 1994 model (Bulman and Schutz, 2008). Although it could be argued that this model is simple, for beginners and does not allow for deep reflection (Bassot, 2015, p. 49) it embraces the significant aspects of reflection (Davis et al, 2011, p. 183) and within the analysis section the trigger questions will allow me to explore my feelings, which Burns and Bulman (2000, p. 32) feel is an essential element of reflection, which creates self-awareness, the underpinning skill of reflection and discussed in the Nursing and Midwifery Councils' standards for registration nursing education (NMC, 2010).

I will focus on the legal, professional and ethical issues associated with the incident, incorporating the Beauchamp and Childress (2013) ethical framework.

My most recent placement was at a community drug and alcohol service in the north of England. One shift I was working with my mentor on the duty desk when Mike, a service user already in treatment for a heroin addiction, presented at the reception desk requesting a re-newel of his methadone prescription as his previous one had

ended and the issue was passed to my mentor as the duty worker to assist Mike with his prescription request. Generally within the service, if a service user is due a repeat prescription their key worker would ensure this has been printed by a prescriber and ready for the service user to pick up if not given during their last appointment. After speaking to Mike my mentor reviewed his electronic clinical notes and identified am alert from his key worker that he had not been attending his appointments or responding to any communication, therefore a repeat prescription would not be provided without a 're-start' appointment with a medical prescriber to ensure it was still safe to provide the methadone. My mentor looked when an appointment could be made and there were no appointments spaces for three weeks, however, due to the situation she could fit him in for an appointment in three days' time at a push.

Therefore, my mentor and I went to speak with Mike and explained the situation, on hearing that he would have to go without his methadone for at least three days Mike became very angry and irate towards my mentor in particular stating he could not wait that that long and demanded a manger. Once a manager spoke with Mike and explained the same, he became even angrier with threats of violence. The manager warned Mike she would call the police if he did not calm down, which he did not, therefore the police were called and Mike left the premises immediately, kicking a door on his departure.

Being part of this situation left me with many questions, some I was able to address immediately after with my mentor, however, I feel by returning to the situation for the purpose of this reflection I will be able to concentrate on some unanswered questions and hopefully learn from the experience and take the knowledge with me as a newly qualified nurse in the coming months.

Firstly, it is important to note that methadone is essentially prescribed to Mike as a replacement for the opiate heroin, to reduce its harm and improve wellbeing (The Royal College of General Practitioners, 2011).

The 'So What?' stage of the Driscoll model (2007) allows for exploration of my feelings at the time of the event. Initially, my feelings were of uncertainty, I was not sure why Mike would not be allowed his methadone prescription as surely he would go into unpleasant opiate withdrawal (Hill et al, 2016) and therefore may substitute his methadone for heroin, surely this could not be the right the decision. This leads me onto the first issue I am going to reflect on which is the professional issue of decision making and accountability. Standing (2007, p. 7) explains that before committing to a decision, nurses should use clinical judgement to evaluate the possible risks and benefits of other choices. When discussing this with my mentor, she explained that there are risks with not prescribing the methadone as Mike may choose to return to risky intravenous (IV) heroin use, however, by prescribing methadone without any review or monitoring also carries a risk.

This relates to accountability which the Royal College of Nursing (2008, p.6) define as "being answerable for one's decisions and actions". Within nursing there is a responsibility to be accountable for your choices and to be able to provide and explanation for them (Wheeler, 2012. P.15). Mutsatsa (2011) expresses that as a nurse you are accountable to your patients, professional body, employer and society and by being accountable to those you have a legal relationship with also creates a legal issue with accountability (Griffith and Tengnah, 2008, p.40).

As being accountable is concerned with protecting patients from harm through your actions (Mutsatsa, 2011, p.40) I feel that harm could be caused to Mike as IV

injecting carries the main physical health risks such deep vein thrombosis and spread of infections like hepatitis and HIV (Caan & de Belleroch, 2002, p.222). However, there are polysubstance misuse issues related to heroin, as heroin is a depressant and can interact with other depressants such as alcohol and benzodiazepines as can increase respiratory depression and result in overdose and death (Hill, Penson and Charura, 2016, p. 10; Caan and de Belleroche 2002, p. 204, Mutsatsa, 2011, p.200) and drugs such as benzodiazepines are commonly used in opiate drug users to ease the withdrawals or extend the 'high' feeling (Caan and de Belleroche, 2002, p. 200), therefore there are risks if unable to monitor for this usage.

Through deeper reflection I can now see that my mentor was acting in accordance with policy and guidelines.

The British National Formulary (BNF) states that service users are at risk of overdose if they have missed three days of methadone (BNF, 2015, p. 427) and if Mike has not been attending his appointments then it cannot be monitored if he has been attending the pharmacy for his daily pick up of methadone. This is echoed by the Royal College of General Practitioners' guidance (2011, p. ii) that missed doses can result in a loss of tolerance and that a review and dose reduction should take place if three days are missed. They also discuss that as a prescriber, treatment needs to be reviewed at every contact with services with frequent urine tests, which is difficult when Mike is not attending his appointments. The National Institute for Health and Care Excellence (NICE) (2007) states service users may need to be monitored and make regular appointments at the centre, fortnightly to begin, then reduced as stability improves. The Department of Health Guidelines (2007, p. 52)

used in my placement area states that failing to attend agreed appointments means an urgent review needs to happen for prescribers to be satisfied the medication safe.

This has left me feeling more comfortable with the decision and my feelings now, that my mentor and the multidisciplinary team were making a decision based on guidelines and policies, it was not simply my mentor reading a comment on the electronic system and doing what it said, it as much deeper that all professionals in the service are working towards the same guidelines, therefore, I understand why my mentor did what she did. I have noticed from my behaviour that I should not jump to conclusions and it has taught me that I will need to be up to date with polices and evidence once qualified and I have to make decisions myself, which is part of the registration requirements of the NMC Code (2015, section 22, p. 17) to keep your knowledge up to date.

Another professional issue I feel was associated with this incident was waiting times and prioritising. Public Health England (2015, p.5) identifies that between 2014-2015 295,244 people had contact with drug and alcohol services, therefore, being the only service within a city suggests resources are going to be stretched and waiting times high. As mentioned, Mike was offered an appointment with a medic within three days for a review and re-induction of a methadone script and the average waiting time was 3.3 days (p. 27), therefore, Mikes appointment was in this time, however, I felt it was too long a wait, even with a priority appointment as these three days create a window to use illicit drugs. I felt empathy towards Mike, but also my mentor as you could see she did not agree with this but there was nothing she could do. Standing (2011, p. 89) discusses that prioritising in decision making involves risk assessment so concentrating on urgent needs over lesser ones, therefore, policy is that if someone misses a methadone script then try to see them sooner, which could be

why the statistics from the Public Health England (2015, p. 27) state that although the average waiting time was 3.3 days it actually commenced at 2.4 days for opiate users, compared to 4.2 days for alcohol only users.

Another professional issue I would like to reflect upon is the importance of record keeping. Immediately after the incident my initial feelings were that a really positive aspect of the situation was the multi-disciplinary communication through electronic records. I thought how awful it would be for my mentor to advise Mike she would get a prescription from the medic, giving him hope, to be told by the medic he is not willing to prescribe, therefore, it is a positive aspect that Mike's key worker left an alert on Mike's account so the information is there straight away. It is important to acknowledge this for my future practice as record keeping enables continuous care and Griffith and Tengnah (2010, p. 181) argue a clinical record is an essential component of care, as important as direct care itself and also has a legal purpose if needed in court should it be needed and it is cited in the NMC code to "keep clear and accurate records (NMC, 2015, section 6, p. 7).

In addition to these professional issues, my initial feelings also raised some ethical considerations for me in relation to the incident, as the four ethical principles of Beuchamp and Childress (2013), which I am most familiar with, seemed to conflict, which I found quite challenging to understand.

The first principle I found challenging was respect for autonomy. Beuchamp and Childress (2013, p. 101) explain this is based upon a service users right to making their own decisions founded on their values and beliefs. I find this rather uneasy in Mike's situation as I feel Mike's decision is to not attend appointments but still be allowed methadone as a replacement therapy to heroin was been overruled,

however, Mike had autonomy over whether to return high risk IV drug use after been educated on the risks, then at the same time you have to consider that it is felt "real addiction is much stronger than the fear of death" (Gossop, 2001, p. 179) and a lack of mental capacity can restrict a person's autonomy (Beuchamp and Childress, 2013, p. 102) and it could be argued that due to the nature of addiction a person such has Mike has limited mental capacity towards decisions about their substance misuse, it feels like their judgement could easily be clouded.

The next principle I found challenging is the non-maleficence, relating to not causing harm, which can be through withholding treatment (Beuchamp and Childress, 2013). As discussed, my confusion arose from the fact that harm would be caused to Mike by returning to IV drug use, however, on reflection there is a significant risk to prescribing methadone without monitoring (DOH, 2007) and Mike has the autonomous decision to decide whether to return to IV drug use, whereas a medic would be accountable for prescribing methadone and causing harm.

This can be interrelated with the principle of beneficence of not only doing no harm but to also do good and improve wellbeing (Beuchamp and Childress, 2013, p. 202) and this was difficult as it could be argued that although as a professional you are not promoting wellbeing if your actions result in Mike returning to IV drug use but you are doing good by preventing harm by prescribing the methadone without monitoring, therefore there is a conflict with my thoughts and feelings, as I can sympathise with both arguments.

The final principle to discuss is justice, which relates to service users been treated fairly and equally within healthcare (Beuchamp and Childress, 2013, p. 249). Reflecting on this issue, I recall feeling Mike was treated fairly in that the outcome

would be the same for other service users in the same situation, I did not sense any inequality. My only concern is that in some situations a service user might have been seen by a medic earlier than the three days, however, this could be down to external factors such as a cancellation in their clinic, more availability, if medics are off sick or on holiday are all factors. I was also concerned that Mike would be prioritised before a non-opiate drug user, as Public Health England (2015, p.27) identifies the average waiting times for alcohol only users was longer than opiate users (4.2 days compared to 3.3 days). A study published by The Lancet by Professor Nutt identified that alcohol was the most harmful drug (Nutt et al, 2010), which highlights some inequality among service users related to their problem.

Reflecting on the ethical issues I feel there is a real conflict going on between them. Cole et al (2014, p. 578) introduce a theory of an institutional control over patients which effect their autonomous decision, this is the case in Mike's situation, the service restricts his decision that he must attend appointments regularly to receive a prescription and denies his choice of methadone replacement, they believe decisions are constrained by healthcare using a paternalistic approach which results in professionals deciding best interests (Beuchamp and Childress, 2013, p. 125). This has led to me feeling how ethics are very complicated and wondering if you are being paternalistic if your decisions as a nurse are based on the best available evidence, something I will research further in the future to develop my understanding and knowledge.

In addition to the professional and ethical issues, I also need to consider the legal issues associated with the incident. One of the legal issues which arose from the situation was the Safety at Work Act (1974) which states it is the duty of every employer to protect others from risk, whether this be violence and aggression. As

discussed, Mike became very aggressive and the police were called, I feel this was quite challenging to watch as he had been given some difficult news and although aggression is not justified I felt some empathetic understanding. However, my mentor and manager did the correct thing in calling the police to protect employees and other members of the public from the risk of violence. To bring back the ethical issue of justice, this does not mean he was banned from the service, the service would usually give verbal, written and a final warning before cancelling treatment all together which there was no record of on Mike's notes prior to this incident. This is also in the NMC Code to "act without delay if you believe that there is a risk to patient safety or public protection" (NMC, 2015, section 16, p. 12). Also, a local trust policy advises to call 999 when there is a threat to person or threat of damage or theft to property (Trust, 2014). NICE (2015) also state that community teams should contact police and not use manual restraint in any situation.

I also felt at the time there was some conflict here with confidentiality by contacting the police as the NMC Code states nurses must "protect people's right to privacy and confidentiality" (NMC, 2015, section 5, p. 6), however, as Wheeler (2012, p. 100) explain nurses are often in a moral dilemma as we have duty to protect the public and abide by the law.

By reflecting on these issues I feel they will have implications in clinical practice and I have been able to highlight the conflict between policy and guidelines and ethical considerations and I definitely aim to research these concepts further. The main learning I will take form this reflection is the importance to abide by policy and guidelines to be accountable for your decisions and actions and always work within the law. I have also learned the importance record keeping has on patient care and also the importance of being self-aware and questioning actions I might undertake or

what I might observe others undertaking. It is important to remember that aside from the policies, legislation and ethical dilemmas that there is an actual person under all that and they should be at the heart of everything, these feeling are felt by Dos Santos (2015) who feels that clinical ethics is focussing on the decision making procedure instead of the person who has the decision. This is important to carry with me in future practice and be aware that reflecting on incidents such as this will be part of revalidation as a qualified nurse to maintain registration with the NMC (NMC, 2016).

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